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Sent via Fax. Hard Copy to Follow by Mail.

John M. Colmers
Secretary
Maryland Department of Health and Mental Hygiene
201 West Preston Street
Baltimore, MD 21201-2399

Dear Secretary Colmers:

Thank you for enabling us to present the first ever comprehensive study of Maryland's Physician Workforce to the Governor's Task Force on Health Care Access and Reimbursement on December 14. MHA and MedChi sponsored this major study effort and fully support the study and its policy recommendations. The study should be a valuable resource to the work of your task force and other physician-related initiatives in the coming years. The study will need to be updated every few years in order to provide a current picture of physician supply, demand, and specialty specific shortages. MHA and MedChi are committed to this ongoing task.

We have reviewed the letter you received from David Wolf of CareFirst (dated January 10, 2008) in which he raises questions about the physician supply numbers presented in the MHA/MedChi study. We are happy to respond to his questions and further explain precisely how our supply numbers were derived and why they are a more accurate picture of Maryland's clinical physician workforce.

OVERVIEW OF PHYSICIAN SUPPLY DATA

The CareFirst letter (specifically Attachment 2) provides a comparison between AMA & DO patient care physicians and MHA/MedChi full-time equivalent physicians in clinical practice by region. A critical oversight of this comparison made by CareFirst is that they are comparing practicing physicians to clinical full-time equivalent physicians. For the MHA/MedChi analysis, the number of practicing physicians was adjusted by the full-time/part-time status of each physician and the percentage of time that each physician spends in clinical activities to arrive at clinical full-time equivalents.

Practicing Physicians

The following summary provides a more accurate comparison of practicing physicians by region based on data provided by both CareFirst and MHA/MedChi.

Maryland Region	CareFirst Data	MHA/MedChi	Variance
Capital Region	6,740	4,581	2,159
Central Region	7,909	8,216	(309)
Eastern Region	979	842	137
Southern Region	399	407	(8)
Western Region	1,464	809	655
State Total	17,167	14,891	2,276

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There are two probable explanations for the variance of 2,276 practicing physicians. First, the MHA/MedChi inventory appropriately excluded federally employed physicians except VA, physicians practicing out of state, non-practicing physicians, and non-renewals. The variation in the Capital Region is probably attributable to the exclusion of both federally employed physicians such as those working in the National Institutes of Health and physicians practicing out of state such as in Washington, D.C. The second factor accounting for these differences is that the MHA/MedChi data were updated through a rigorous review and editing process in each local market where retired and deceased physicians and physicians who have relocated out-of-state were excluded from the practicing physician count. New physicians were, in turn, added to the practicing physician count.

Clinical Full-Time Equivalent Physicians

In order to fully define physician supply, it is critical as part of any physician workforce study to define the actual number of clinical full-time equivalent physicians who are available for direct patient care. As part of the editing process that was previously referenced, The Johns Hopkins and University of Maryland Health Systems and Medical Schools and the freestanding teaching programs across Maryland provided information on the percentage of time their faculty spends on teaching, administrative, and research functions for each type of physician specialty. Based on this input, the baseline data that was obtained from the Maryland Board of Physicians was adjusted to account for both the part-time/full-time status of each physician and the percentage of time each physician spends in clinical practice. The following regional breakdowns of practicing physicians, clinical full-time equivalent physicians, and the average full-time clinical equivalent per practicing physician are provided.

Maryland Region	Practicing Physicians	Clinical FTEs	Avg. FTE Per Physician
Capital Region	4,581	3,238	0.71
Central Region	8,216	5,278	0.64
Eastern Region	842	669	0.80
Southern Region	407	362	0.89
Western Region	809	672	0.83
State Total	14,891	10,277	0.69

Based on data from the October 2006 HRSA study titled, "Physician Supply & Demand: Projections to 2020," the average clinical full-time equivalent per practicing physician is 0.79 in the U.S. versus 0.69 in Maryland. The three rural regions exceed the national average; whereas, the Capital and Central regions are lower than the national average. There are two principal reasons for these variances. First, Maryland trains a disproportionately larger percentage of residents in relation to its population. Second, a more in-depth analysis was conducted in Maryland to quantify the impact that teaching, research, and administrative functions have on a physician's full-time equivalent status.

Patient In-/Out-Migration

The Maryland Health Care Commission has analyzed the impact of patient in-migration and out-migration on the demand for both acute care services and medical services as part of its overall

research activities. One recent study of Medicare claims data identified that there is materially no net impact on the demand for medical services based on in-/out-migration. The Steering Committee for the Maryland Physician Workforce Study discussed this issue at length as part of formulating the underlying assumptions for the physician requirement modeling. The committee concluded that the impact of patient in-/out-migration should be held neutral so that it is both consistent with the research approach utilized by the Maryland Health Care Commission and with the approach that was utilized in other statewide physician workforce studies.

Physician Shortages in Maryland

We hope this explanation helped clarify further the accuracy of the MHA/MedChi study's physician supply numbers. The bottom line is there is irrefutable evidence for the following conclusions:

1. The three rural regions in Maryland have significantly fewer physicians per 100,000 population and face dramatic physician shortages.

2. There are many specialties with current statewide shortages such as primary care, general surgery, thoracic surgery, emergency medicine, and dermatology.

3. Maryland is faced with an aging physician workforce, particularly in the medical and surgical specialties and the Capital Region.

4. Maryland is now competing nationally for scarce physician resources and is currently at a disadvantage from a practice cost, reimbursement, and cost of living standpoint.

Absent innovative initiatives to address these issues, Maryland will continue to face a physician shortage crisis.

We are confident that your task force will consider the MHA/MedChi study rigorous and accurate, more comprehensive, and more useful than the limited information provided by CareFirst. Should you need additional information, please contact us as follows: Robert Barish, M.D., 410-706-1412 or at RBarish@som.umaryland.edu; David Boucher, 315-655-2630 or at boucher@dreamscape.com.

Sincerely,

Robert Barish

Robert A. Barish, M.D., Chair
Maryland Physician Workforce Study
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